Original Research Paper

Volume - 13 | Issue - 11 | November - 2023 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Economics

ARE SAARC MEMBERS COUNTIES ACHIEVED THE MDGS 5?

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ABSTRACT The overall proportion of deaths to women of reproductive age (15–49 years) that are due to maternal causes (PM) was estimated at 9.2 percent (UI 8.7% to 10.6%) in 2017 – down by 26.3 percent since 2000. This means that compared with other causes of death to women of reproductive age, the fraction attributed to maternal causes is decreasing. This study based on the secondary data. The overall proportion of deaths to women of reproductive age that are due to maternal causes was estimated to be 26.3% lower in 2017 than in 2000. The lifetime risk for a 15-year-old girl of dying of a maternal cause nearly halved between 2000 and 2017, globally, from 1 in 100, to 1 in 190. The global community should accelerate efforts, because if we only continue with the same rate of progress as achieved during this period, it will not be possible to reach the global SDG target of less than 70 maternal deaths per 100 000 live births by 2030.

KEYWORDS : MMR, Reproductive and Problems

INTRODUCTION

A maternal death is not only a tragedy to the family but also impacts negatively on the society. Additionally it is an indicator that is utilized to measure the overall health of a population and is used to compare the health status of countries globally (Soma Sajedinejad 2015, Wilmoth et al., 2012 and WHO 2014). The global lifetime risk of maternal mortality for a 15-year-old girl in 2017 was estimated at 1 in 190; nearly half of the level of risk in 2000: 1 in 100. The overall proportion of deaths to women of reproductive age (15–49 years) that are due to maternal causes was estimated at 9.2 percent (UI 8.7% to 10.6%) in 2017 – down by 26.3 percent since 2000. This means that compared with other causes of death to women of reproductive age, the fraction attributed to maternal causes is decreasing.

India had the highest estimated numbers of maternal deaths, accounting for approximately one third (35%) of estimated global maternal deaths in 2017, with approximately 67 000 and 35 000 maternal deaths (23% and 12% of global maternal deaths), respectively. The global HIV- related indirect Maternal Mortality Rate (MMR) was estimated at three maternal deaths per 100000 live births. HIV and pregnancy interaction accounted for 1.22 percent of maternal deaths globally. Bhutan was one of the nine countries to have achieved the millennium development goal five in 2015 to global maternal mortality by three – quarters between 1990 and 2015. The study stated that a lot of work to reduce the preventable causes of maternal health. Annual maternal death investigation review reports finding that a gradual decline in the number of mother dying every year. This is due to continued good policy and active intervention by the reproductive health programme.

Problems

Globally, the total number of maternal deaths was decreased by 43 percent from 532000 in 1990 to 303000 in 2015. The global MMR declined by 44 present from 385 maternal deaths per 100000 live births in 1990 to 216 in 2015 an average annual decline of 2.3 percent (WHO, 2015) of the 183 countries included in this exercise, a countries that had high level of maternal mortality in 1990 are categories is having met the MDG of having reduced maternal mortality by 75 percent. They are Maldives (90 percent), Bhutan (84 percent) Cambodia (84 percent), caboverde (84 percent), the Islamic republic of Iran (80 percent), Timor – larle (80 percent) lao peoples' democratic republic (78 percent), Ruanda (78 percent) and mongolia (76 percent). An additional 39 countries are characteristic as having made a 50 percent reduction in maternal mortality, 21 countries have mode insufficiency progress and 26 made no progress.

Many developing regions have made steady progress imposing maternal health including the regions with the highest maternal mortality rations. Every day hundreds of women die during pregnancy or form childbirth-related complication. In 2013, most of these deaths were in the developing regions, where the maternal mortality ratio is about 14 times higher than in the developed regions. Globally, these were an estimated 2,89,000 maternal deaths in 2013, equivalent to about 800 women dying each day. Major complications include infections, high blood pressure during pregnancy complications from delivery and unsafe abortion.

Methods

This study was based on the secondary data. The data collected from world Health Organization data search. The data period was from 2000 to 2017. The study covered only SARRC region. There are eight countries in SARRC region such as Afghanistan, Bangaladesh, Bhutan, India, Maldives, Nepal, Pakistant and Sri Lanka. The study focused only maternal death in SARRC Region.

ANALYSIS AND DISCUSSION

In September 2000, world leaders came together at the United Nations headquarters in New York to adopt the United Nations millennium declaration committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time- bound targets with a deadline of 2015 that have become known as the Millennium Development Goals (MDGs).

Table – 1 Maternal Mortality Ratio of SAARC Region

Year/ countries	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri lanka
2000	1450	434	423	370	125	553	286	56
2001	1390	423	384	354	111	521	275	53
2002	1300	410	365	336	105	520	264	50
2003	1240	395	348	319	97	470	254	50
2004	1180	372	332	303	89	447	243	48
2005	1140	343	310	286	75	415	237	45
2006	1120	315	291	270	71	386	222	47
2007	1090	297	275	255	71	361	214	43
2008	1030	280	264	240	72	342	205	42
2009	993	269	255	225	71	323	199	41
2010	954	258	247	210	67	305	191	38
2011	905	248	239	197	62	285	180	38
2012	585	238	231	185	60	266	173	37
2013	810	227	223	175	58	248	166	36
2014	786	214	214	166	56	231	161	36
2015	701	200	203	158	54	236	154	36
2016	673	186	193	150	54	200	143	36
2017	638	173	183	145	53	186	140	36
Overall reduction in MMR between 2000 and 2017(%)	56	60	57	61	58	66	51	36

Source: World health organization

WHO defines maternal death as: the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes. This definition allows identification of a maternal death, based on the cause of the death being recorded as either a direct or indirect maternal cause. The number of maternal

deaths in a population (during a specified time period, usually one calendar year) reflects two factors: (i) the risk of mortality associated with a single pregnancy or a single birth (whether live birth or stillbirth); and (ii) the fertility level (i.e. the number of pregnancies or births that are experienced by women of reproductive age: 15–49 years).

Afghanistan

Afghanistan has one of the highest maternal mortality rates in the world. The maternal mortality ratio was 1800 death per 100000 live births in 2005, meaning that almost two out of every 100 women died due to pregnancy or child birth related issue (Prfisterer, 2011). Afghanistan suffered a server a severe shortage of skilled health care workers, which made women much more likely to suffer from maternal deaths. Also the inaccessibility and lack of health care facilities made it much more difficult to receive prenatal care and care during birth because of these harsh laws that restricted women's opportunities to seek health care. After 2006 the maternal mortality rate was decreased from 1120 to 638 in 2017. Overall reduction in MMR between 2000 and 2017 was 56 percent in Afghanistan.

Bangladesh

The maternal mortality was 343 in 2000. It is noted that 85 percent of maternal deaths in Bangladesh result from direct obstetric causes. There are primary haemorrhages among women aged over 25 years and eclampsia among younger women aged 15-24 years (NIPRT, 2003). Maternal mortality is extremely high during labour on the delivery day and within 48 hours after delivery. In mat lab for example, 40 percent maternal deaths from all causes occurred at these times during 1976-1985 prior to any intervention (Fauveau et al., 1988). Around 45 percent of women in Bangladesh suffer from a chronic energy deficiency (Shety et al., 1995). Over 43 percent of women in the country are iodine deficient and more than 2.7 percent are night blind during pregnancy (Bangladesh ministry of Health and Family Welfare, 2000). Majority of women in both urban and rural areas reported rickshaw or van as their primary means of transport to be used during pregnancy delivery and emergencies (Rahman, 2000). It can be observed from the table that Bangladesh taken necessary steps to reduce MMR through development of medical facilities and practitioners. Overall reduction in MMR between 2000 and 2017 was 60 percent. It is high compared with Afganistan (56%), Bhutan (57%), Maldives (58%) and Pakistan (51%).

Bhutan

The cause of maternal deaths in Bhutan is based on the three delay model. They are delay at home, which means patients and family members are not aware to seek care and delay in seeking care. Delaying to reach a hospital due to lack of transportation, roadblock and long distance are in the second delay. Delay at the hospital is the third that causes maternal mortality. This is due to shortage of staff, staff not in the station, medicine storage equipment not working and sub-optimal lake. The main challenge is now with third delay that is not receiving the appropriate treatment in time at the health facility due to human resource shortage and logistic deficiencies. There is a new trend in Bhutan which is the fourth delay that is deliberately not seeking care for socio reasons. Women (6.7 percent) were married before age 15 and 30.8 percent before 18. The adolescent fertility rate is 40.9 births per 1000 women age 15-19. Inequity in access to maternal health services is a barrier toward MDGs. little variation in contractive prevalence rate is observed across residence in Bhutan.

Increasing female literacy rate from 33 percent in 2003 to 59 percent in 2017 has a huge invisible contribution towards the improvement of maternal health in Bhutan. In 2017 about 93.6 percent of the total delivers took place at the health facilities 83.2 percent more than in 1994 (10.40 percent). Among others improving the quality of service at health facilities improves the maternal health in the country. The MMR declined from 900 deaths per 100000 live births in 1990 to 120 in 2013, reflecting an average annual decline of 8.4 percent (WHO, UNICEF, UNFPA & the World Bank, 2014). Overall reduction of MMR between 2001 and 2017 was 57 percent. It is high compared with Sri lanka.

India

India is responsible for the second highest number of maternal deaths worldwide (SRS, 2018). Indian government, the MMR dropped from over 400 per 100000 in the early 1990's to 230 in 2008 and to 130 per 100000 between 2014 and 2016. In the southern state of Kerala, in India the MMR has reported be as low as 61 per 100000 live birth in 2013. Whereas in the northern state of Bihar it was 208 per 100000 live births, 92.4 percent of the women dying in pregnancy suffered at least one complication of pregnancy, compared with 26.3 percent of women suffering pregnancy. Women between ages of 25-29 years least likely to die during pregnancy. The youngest age group, women between 13 and 19 years was the group the highest risk of death is pregnancy followed by the older group of women of between 40 and 49 years of age. Since 2005, India has been improvements institutional deliveries from 39 per in 2005 to 79 percent in 2013. Complete antenatal care coverage increased from 37 percent to 51.7 and postnatal care increased from 23 percent to 36 percent (IIPS, 2017). Overall reduction in MMR between 2000 and 2017 was 61 percent. It is high compared with Afghanistan, Bangladesh, Bhutan, Maldives, Pakistan and Sri Lanka. The Counselling for health related issues need immediate attention to health project and keep improve the human health and development for overall economic development (Rajendran and Ramachandran (2015).

Maldives

Anaemia is a chronic health problem among women in the Maldives. In 2001, the multiple indicator cluster survey reported that 51 percent of women of reproductive age were anemic and that the rate was at 56 percent among pregnant women. It found that overall 38 percent of women were iron deficient. Among women 26.8 percent were found to have zine deficiency and 4.7 percent women and 39.3 percent women have severe and moderate vitamin A deficiency respectively. Emergency Obstetric Care (EmOC) at atoll level was strengthened institutional deliveries were encouraged and the phasing out of the service of traditional birth attendants with little or no training were seen to bring positive outcomes in reducing maternal mortality in Maldives. Immunization is one of the most cost effective public health interventions since it provides direct and effective protection against preventable morbidity and mortality (Rajendran and Ramachandran, 2013). Immunization is largely responsible for reduction of under 5 mortality rate. MMR was decreased from 111 in 2001 to 71 in 2007 it is increased 72 in 2008. Thereafter it was decreased from 71 in 2009 to 53 in 2017. Overall reduction in MMR between 2000 and 2017 was 58 percent in Maldives.

Nepal

Nepal is still facing challenges to reduce Maternal Mortality Rate (MMR) as per the national and global target the statistics is 239 per 1,00,000 live births. Nepal faces more challenges in providing health care sources than developed countries. In the context of Nepal factors such as poverty, illiteracy, lack of infrastructure, shortage of health care professionals, attitude towards medical professional, health insurance policies, geographic distribution, culture, governmental policies and physical barriers also directly affect health care services being provided (Rai et al., 2001, Ashworth et al., 2019) the MMR was 305 per 100000 in 2010, which improved to 186 per 100000 in 2017. Overall reduction in MMR between 2000 and 2017 was 66 percent.

Pakistan

The country also has huge challenges of political fragility, complex security issues and natural disasters. Efforts to improve maternal health improve training and availability of skilled personal in both government and private sector. 60 percent of all births in Pakistan occur at home by unskilled birth attendants (Federal Bureau of Statistics 2007). In the community 78.1 percent of the deaths were due to direct causes and 21.9 percent to indirect causes. Hemorrhage was responsible for over half the death is 52 percent. The second most common causes was sepsis (16.3 percent) followed by eclampsia (14.4 percent) and obstructed labor (6.5 percent), abortion caused 5.2 percent of the deaths. Among the indirect causes hepatitis was the most common (14 percent) followed by heart diseases 9.3 percent. Female mobility, distance of health care facilities and purchasing power are some of the factors limiting access. About two-thirds of women reported at least one problem in accessing health care for themselves (67 percent). About three-fifths of women reported not wanting to go alone (58 percent) for two fifths distance to a health facility was a problem (42 percent) about one third of women recounted problems getting money for treatment (30 percent) and on fifth mentioned that getting permission for accessing health care was a big problem (21 percent) (PDHS, 2017-2018). MMR in Pakistan was continuously decreased from 275 in 2001 ti 140 in 2017. The overall reduction in MMR between 2000 and 2017 was 51 percent.

Sri Lanka

Maternal mortality has fallen strikingly from approximately 2000 per

100000 live births in 1930 to 33.8 per 100000 live births by 2016. Between 2002 and 2010 maternal suicide rations sharply increased from 0.8 to 12.1 suicides per 100000 live births. The effect of suicide during pregnancy or during the immediate part partum period is far reaching. Apart from the calamity of the loss of life of a mother, it inflicts significant negative health and socio economic impacts on living children the family and community (WHO 2013). Inadequate maternal health literacy among health care professional who interest with pregnant and post-partum mothers is a major drawback in the prevention of maternal suicides. Effective management including the use of information for monitoring and planning reinforced the two early building blocks of Sri Lanka success in reducing maternal deaths access to basic health services and professional midwifery infrastructure and man power play a major role in providing quality maternal care that is needed to reduce MMR. Health promotional activities at antenatal clinics are the suitable method to disseminate knowledge to the public. Overall reduction in MMR between 2000 and 2017 was 36 percent.

CONCLUSION

Global MMR in 2017 had declined 38 percent since 2000, when it was estimated at 342 maternal deaths per 100 000 live births. The average annual rate of reduction in global MMR between 2000 and 2017 was 2.9 percent; this means that, on average, the global MMR declined by 2.9 percent every year between 2000 and 2017. The global number of maternal deaths in 2017 was estimated to be 35 percent lower than in 2000 when there were an estimated 451 000 (UI 431000 to 485 000) maternal deaths. The overall proportion of deaths to women of reproductive age that are due to maternal causes (PM) was estimated to be 26.3 percent lower in 2017 than in 2000. The lifetime risk for a 15-year-old girl of dying of a maternal cause nearly halved between 2000 and 2017, globally, from 1 in 100, to 1 in 190. The global community should accelerate efforts, because if we only continue with the same rate of progress as achieved during this period, it will not be possible to reach the global SDG target of less than 70 maternal deaths per 100 000 live births by 2030.

REFERENCES

1. Ashworth et al., (2019), "Health Care Accessibility in the Rural Plans (TERAI) of Nepal physical factors and associated attitudes of the local population", *International Health*, 11:528-535.
2. Federal bureau of statistics (2007), "Pakistan demographic survey 2005 Islamabad", federal Bureau of statistics division, Federal Bureau of statistics.
3. Pakistan demographic Health survey (2017-18).
4. Rajendran S and R.Ramachandran (2013), "Understanding of Trends on Vaccination in India", *International Journal of Research and Development*, II (II):1-14.
5. Rajendran S and R.Ramachandran (2015), "Counselling for Patients in Rajapalayam Government Hospital", *International Journal of Scientific Research*, 4 (5):236-238.
6. Rai et al., (2001), "The health system in Napal- an introduction", Environ Health Previ Med, 6:1-8.
7. WHO (2013), "Maternal suicides in Sri Lanka: lessons learnt from review of maternal deaths over a year (2002-2010) in suicide in Sri Lanka: Past present and future transformations", WHO.
8. WHO, UNICEF, UNFPA and The World Bank (2014), "Trends in maternal mortality: 1990 to 2013", WHO.